APPLICATION FOR APPROVAL OF CONTINUING EDUCATION FOR OPTOMETRY AND OPTOMETRIC LEGEND DRUG HOURS
March 2007

INDIANA OPTOMETRY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2054
Email: pla8@pla.IN.gov

DATE RECEIVED (month, day, year)	
APPROVAL DATE	
CONTIUING EDUCATION HOURS GRANTED	

SPONSORING ORGANIZATION			
Name of Sponsor			Type of Organization
Address (number and street, or post office box)			
City	State		ZIP Code
Telephone number	FAX number	Email address	Website

PROGRAM COORDINATOR		
Name of Program Coordinator		Title
Mailing Address (number and street or post office box)		
City	State	ZIP Code
Telephone number	Fax number	Email address

COURSE/SEMINAR TO BE OFFERED			
OPTOMETRY HOURS	☐	**OPTOMETRIC LEGEND DRUG HOURS**	☐

TITLE OF PROGRAM

Date(S)	**Location (city and state)**

CONTINUING EDUCATION HOURS REQUESTED	
TOTAL NUMBER OF HOURS PER PROGRAM	

HOURS OFFERED PER CATEGORIES
(Please specify the number of hours for each category)

Therapeutic		**Pharmacology**		**Optometry**	

TYPE OF PROGRAM

☐ Conference ☐ Seminar ☐ Short Course ☐ Institute ☐ Workshop ☐ Grand Rounds

☐ Special Training Program ☐ Other _____

NAME OF INSTRUCTORS

Please list the names of instructor(s). Attach curriculum vitas or resumes.

NAME OF LECTURER	ACADEMIC AND PROFESSIONAL BACKGROUND

OBJECTIVES

List the objectives for the continuing education course

CONTENT OF PROGRAM

Provide the Board with a brief summary of the content of the program below. Attach a detailed course outline or printout of the Power Point presentation.

RECORD OF ATTENDANCE

Who will monitor attendance?

What is the manner in which attendance will be monitored?

Who will maintain adequate records of course participants and agree to provide participants with a record of attendance and to retain records of attendance by participants for three (3) years form the date of the program?

What is the method of certifying attendance?

Does the "Record of Attendance" that will be awarded to the optometrist state the following:

a. Sponsor of the program? ☐ Yes ☐ No
b. Name of the program? ☐ Yes ☐ No
c. Date of the program? ☐ Yes ☐ No
d. Number of continuing education hours? ☐ Yes ☐ No
e. Does it state whether they are optometry hours or optometric legend drug hours? ☐ Yes ☐ No

NOTE: Each participant must be provided a record of attendance.

ADDITIONAL INFORMATION REQUESTED

1. Have you enclosed the following items:
   a. One (1) original and one (1) copy of your application for continuing education approval? ☐ Yes ☐ No
   b. One (1) original and one (1) copy of the detailed course syllabus or outline, printed Power Point presentation, brochures, evaluation form and curriculum vitas or resume? ☐ Yes ☐ No

2. Have you applied for continuing education approval with any other entity? ☐ Yes ☐ No :	
If yes, please specify:	
3. Is there an examination administered? ☐ Yes ☐ No	
If yes, what is the pass rate?	
4. Have you read and reviewed 852 IAC 1-16 and 852 IAC 2-2 regarding the approval of continuing education programs for optometrists and optometric legend drug certificates? ☐ Yes ☐ No	
APPLICATION AFFIRMATION	
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.	
Signature of program coordinator	**Date signed (month, day, year)**